MEDICAL/DIETARY QUESTIONNAIRE

PUPIL'S NAME ____ D.O.B _____/______/______

PARENT'S NAME AND INITIALS ____

HOME ADDRESS ____

____

TELEPHONE NO. ____

NAME AND ADDRESS OF FAMILY DOCTOR ____

____

____

TELEPHONE NO. ____

SCHOOL Maidenbower Junior School

Has your child had any of the following:-

Asthma or Bronchitis	YES	NO
Heart Condition	YES	NO
Fits, fainting or blackouts	YES	NO
Severe Headache	YES	NO
Diabetes	YES	NO
Allergies to any known drugs or medication	YES	NO
Any other allergies e.g. material, food, insect bites etc.	YES	NO
Other illness or disability	YES	NO
Any recent contact with contagious diseases and infections	YES	NO

If the answer to any of these questions is YES please give details on the reverse of this form.

Immunisation Status

Has your child received vaccination against Tetanus in the last ten years? YES NO

Is your child receiving medical treatment of any kind from either your family doctor or hospital? YES NO

Has your child been given specific medical advice to follow in emergencies? YES NO

If the answer to either of these questions in YES please give the details here: - (including dosage of any medicines/tablets)

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Please inform us of any dietary requirements (allergies/intolerances):